EXHIBIT G

Medical Mutual Insurance Company of North Carolina
Entity Professional Liability Application

Print

Non-Assessable Claims-Made, Claims-Made Plus or Occurrence Coverage

Applicant's Instructions

- A separate application must be completed for each joint venture, partnership, or corporation.
- Attach copies of all Articles of Incorporation, Partnership Agreements, etc.
- If space is insufficient to answer any questions fully, use the Additional Comments Section at the bottom of this form, or attach separate documentation.
- Use the **"Check for Errors"** button to ensure all required information has been provided.
- Use the **"Submit"** button for attestation and completion.

Issue Company *	**Medical Mutual Insurance Company of North Carolina**
Issue State *	**VA**
Policy Type	**P&S PL Org**

Practice

Legal Name *	**Pediatric Partners for Attention and Learning, Inc.**
Web Site Address	**www.pp4al.com**
Tax ID (omit dashes)	**455487821**

Office Manager or Contact

First Name *	**Joni**
Last Name *	**Johnson, MD**
E-mail Address *	**jonijj68@gmail.com**
Phone *	**5406284145**
Fax	**5406284192**

Practice Mailing Address

Address Line *	**2128 Jefferson Davis Hwy., Ste. 201**
Address Line 2	
City *	**Stafford**
State *	**VIRGINIA**
Zip Code *	**22554**

Practice Names

If the Applicant does business under any other name, please list all additional names:	**Partners for Attention and Learning, inc.**

Billing Address (if different from mailing address)

Address Line 1

Address Line 2

City

State

Zip Code

Coverage

Practice State * *	**VA**
Practice County *	**Stafford**
Desired Effective Date *	**09/01/2017**
Desired Coverage Type *	**Claims-Made**
Desired Limits (Each Claim/Aggregate) *	**$2,350,000/$7,050,000**

Practice Locations

	Address Line 1	Address Line 2	City	State	Zip	Phone	Fax
1	2128 Jefferson David Hwy.	Suite 201	Stafford	VA	22554	5406284145	5406284192
2	1146-E Walker Road		Great Falls	VA	22066	7035398310	5406284192
3							
4							
5							
6							
7							
8							

Organization

Type of Practice (select the one most appropriate) *	**Single Specialty Practice**
Type of Organization (select the one most appropriate) *Note: Non-Profit Organizations must attach list of Board of Directors and Shareholders along with proof of non-profit status.* *	**Solo Incorporated**
If the Applicant is a joint venture, disclose the parties in the joint venture and their percentage participation.	
If the Applicant owns a subsidiary(ies), disclose that subsidiary here and indicate its type of organization.	
Will the Applicant be covered by any additional professional liability insurance policy with any other insurance company?	**No**

Prior Acts Coverage

(NOTE: Prior Acts Coverage is optional and subject to underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier.)

Do you desire Prior Acts coverage? *	**Yes**
Retroactive Date *	**11/01/2012**

Prior Acts Coverage Certification

I request Prior Acts Coverage retroactive to 11/01/2012 , which is consistent with the attached Declarations page from my current carrier.

I certify that I have no knowledge of any professional liability claims which have been asserted against this applicant, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior or applicable carrier.

I furthermore certify that I have no knowledge of any occurrence, incident or circumstance likely to result in such a claim as of this date, other than those reported on this application.

Notice of any such claim, incident or circumstance should be given to your carrier if such notice has not already been provided. This policy will not provide coverage for any such claim, occurrence, incident or circumstance.

I certify that the above is true complete and correct to the best of my knowledge, information and belief. I understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

General Information

Does the Applicant's collection agency or billing company have authority to file a collection suit at its discretion without prior approval of the Applicant? *	**No**
Has the Applicant or any of its employees ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental or administrative agency, hospital, or professional association? *	**No**
Has the Applicant or any of its employees ever been indicted for, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges or medical licenses revoked, suspended, restricted, placed on probation or voluntarily surrendered? *	**No**
Has the Applicant or any of its employees ever filed for bankruptcy? *	**No**
Does the Applicant contract with other companies, practices or hospitals to provide service?	**No**
Does the Applicant advertise?	**Yes**
If yes, explain: *	**social media presence, attends events as a service vendor, may run an advertisement in a local parents magazine, etc.**
Does the Applicant maintain current certificates of insurance on file for all doctors and allied healthcare providers employed, contracted or privileged at its facility(ies)? *	**Yes**
Does all biomedical equipment receive scheduled preventative maintenance annually by a qualified biomedical equipment technician? *	**No**
Is your biomedical equipment checked by your employees on a routine basis? *	**Yes**
If yes, are these check logs maintained in your practice? *	**No**
Does the Applicant reuse any medical devices?	**Yes**
If yes, does your practice have a Reuse policy? *	**No**
Do you follow the manufacturer's guidelines on reuse? *	**Yes**
Does the Applicant have an Ambulatory Surgery Center? *	**No**
Does the Applicant provide pathology services? *	**No**
Does the Applicant provide walk-in clinic services? *	**No**
Does the Applicant dispense medications other than free samples?	**No**
Does the Applicant provide diagnostic imaging/X-ray services? *	**No**

General Information - Annual Numbers

Clinic Visits *	3,000
Surgeries *	0
Revenues ($) *	480,000

Insurance History

	Company	Policy Number	Coverage Form	From	To	Deductible	Deductible Amount	Liability Limit	Retroactive Date
Current Carrier*	Prof. Advocate	VA9-0089011-01	Claims-Made	03/14/2017	09/01/2017	No		3,000,000	11/01/2012
First Prior Carrier									
Second Prior Carrier									
Third Prior Carrier									
Fourth Prior Carrier									

Coverage Information

Has this medical practice or entity ever had any professional liability insurance refused, cancelled, or non-renewed? * **No**

List any non-physician owners and their percentage of ownership.

Please identify all owners, employed and contracted physicians within your organization, and provide information concerning each member in each category listed in the following table:

	Last Name	First Name	MI	Degree	Specialty	Role	Coverage Status	Medical Mutual Policy Number	Percentage of Ownership
1	Johnson	Joni	J	MD	Pediatrics	Shareholder	Requesting individual coverage with Medical Mutual		100
2									
3									
4									
5									
6									
7									
8									

Non-Physician/Non-Dentist Personnel

Do you employ or contract with any non-physician or non-dentist personnel? * **Yes**

Provide the number of personnel for each category:

Nurses *	0
CRNAs *	0
Nurse Midwives *	0
Podiatrists *	0

Pharmacists *	0
Nurse Practitioners *	1
Physician Assistants *	0
Chiropractors *	0
Dental Assistants/Hygienists *	0
Psychotherapists *	0
Licensed Clinical Social Workers *	2
Anesthesia Assistants *	0
Other *	2
Please specify: *	**Licensed Professional Counselors**

Claims History

Attach current Loss Run (No more than 90 days old) for previous 10 years of practice. (A *loss run* is a document from your previous professional liability carrier(s) verifying claims, suits or reported incidents.) **Your application will not be processed without this information.**

1.) Have any claims or suits been brought against the entity or medical practice, or have any incidents concerning professional services been reported? *	**No**
2.) Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you? *	**No**

e-MD Network Privacy & Security Coverage and/or Broad Regulatory Protection Coverage

Are you interested in speaking with someone regarding higher limits of coverage for e-MD Network Privacy & Security Coverage and/or Broad Regulatory Protection Coverage? *	**Yes**

Additional Comments

Authorization and Release

I, the undersigned Applicant, understand that this is an application and is not an insurance binder. I certify the representations in this application to be true and understand that the policy if issued, is conditioned upon the truth of the representations in this application. I further understand that the falsity of any representations made in this application for insurance could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

I, the undersigned Applicant, authorize the release and exchange of information involving either underwriting or claim matters between my present or prior insurance carrier, any hospital and other physicians and the Company. I hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

*** *Signed by* ***Jonijj68@gmail.com*** *using password confirmation on* ***06/19/2017 - 22:17:47*** ***